

Does integrated health and care in the community deliver its vision? A workforce perspective

Integrated
health and care
in the
community

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Abstract

Purpose – The purpose of this paper is to explore and capture workforce perceptions, experiences and insights of the phenomena of integrated care (IC) in a community health and care NHS trust in England; including whether there are any associated factors that are enablers, barriers, benefits or challenges; and the level of workforce engagement in the process of integrated health and care.

Design/methodology/approach – A qualitative design based on an interpretivist research paradigm was used with a purposive sampling technique. Five in-depth semi-structured interviews were conducted with community nursing, social workers and allied health professionals. Colaizzi's (1978) descriptive phenomenological seven-step method was applied to analyse data, with the emergence of 170 significant statements, 170 formulated meanings and 8 thematic clustering of themes to reveal 4 emergent themes and 1 fundamental structure capturing the essential aspects of the structure of the phenomenon IC.

Findings – This study revealed four interdependent emergent themes: (1) Insight of IC and collaboration: affording the opportunity for collaboration, shared goals, vision, dovetailing knowledge, skills and expertise. Professional aspirations of person-centred and strength-based care to improve outcomes. (2) Awareness of culture and professionalism: embracing inter-professional working whilst appreciating the fear of losing professional identity and values. Working relationships based on trust, respect and understanding of professional roles to improve outcomes. (3) Impact of workforce engagement: participants felt strongly about their differing engagement experience in terms of restructuring and redesigning services. (4) Impact of organisational structure: information technology (IT) highlighted a barrier to IC as differing IT platforms prevent interoperability with one system to one patient. Shared positivity of IC, embracing new ways of working.

Originality/value – This study proposes considerations for future practice, policy and research from a local, national and global platform, highlighting the need for any IC strategy or policy to incorporate the uniqueness of the “voice of the workforce” as a key enabler to integration developments, only then can IC be a fully collaborative approach.

Keywords Integrated care, Collaboration, Professionalism, Culture, Workforce engagement, Organisational structure, Information technology, Phenomenology

Paper type Research paper

Introduction

Key transformational drivers for integrated care (IC) reflect the national recognition for integration across health and social care with rising numbers of people living with complex health and social care needs (National Health Service (NHS) England, 2014; NHS England, 2019a). The design of community services for the needs of local populations is fundamental to integration (NHS England, 2014; NHS England, 2019a). The increasing demand for complex long-term care serves to address the triple aim of simultaneously improving population health, patient experience and cost efficiency at national and global level (Berwick *et al.*, 2008; Hawkes, 2013; NHS England, 2014; NHS England, 2019a), with The Care Act,

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UK Government (2014) encouraging and formalising IC including adult social care integration within the NHS and plan for one fully integrated sector (Hunt, 2018).

The World Health Organization (WHO, 2016) defines the concept of IC as “An approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care” (p. 10). This is further endorsed by the Social Care Institute for Excellence (2019) asserting the fundamental objective of IC is the delivery of person-centred joined up care and the core principle of a “whole system” approach with system leadership.

Indeed, there is a change of landscape of health and social care in the community with the movement of integrated care systems (ICSs) through development of sustainability and transformation partnerships (STPs), local “place-based” partnerships of NHS and local authority organisations. This brings together GPs, hospitals, mental health and social services (NHS England, 2017), serving the principle of subsidiarity across the whole system (Charles *et al.*, 2018). The NHS Long Term Plan highlighted by 2021 ICSs will cover the whole country with primary care networks’ key visioning collaboration across organisational boundaries, improving the use of resources, advancing the health and well-being of their populations with care closer to or at home and fully integrated community-based health care a priority (NHS England, 2019a; Murray, 2019).

The NHS enduring success is a result of the 1.5m workforce’s brilliance (NHS England, 2018), with the performance of any health care system ultimately reliant on employees (NHS England, 2019a). Additionally, Britnell (2019) points out universally the truism of “there is no healthcare without the workforce” (p. 9) is acknowledged yet inadequately addressed. The voice of the workforce is imperative as Lees *et al.* (2017) indicate IC success is not solely the reduction of hospital admissions but should also include patient experience, professional opinion and experiences of staff and clinicians.

This is further compounded by a clear message of “Think Integration, Think Workforce” as a key determinant for the success of integrating services and when organising systems to deliver outcomes for and with patients (Centre for Workforce Intelligence, 2013). Likewise, NHS England (2014) resonates, whilst we can design innovative new care models, unless we have a workforce with the right numbers, skills, values and behaviours, it will not become a reality. Hence, capacity, capability and motivation of staff to engage are essential in complex service redesign including engagement in dialogue with health and care professionals (The House of Commons Health and Social Care Committee (HCHSCC), 2018).

The study’s primary intent was to explore workforce perceptions from professional experience and perspectives to support and understand the context of the discipline of IC in practice. Johnson *et al.* (2012) and Schwartz *et al.* (2011) attribute professional identity as one’s professional self-perception. Schein (1978) describes professional identity as an enduring collection of inextricably associated concepts of self, based on individuals’ experiences, attributes, beliefs, values and experiences in terms of their perception of themselves in a professional role. Furthermore, Rothausen *et al.* (2015) state issues of professional identity highlight the importance of beliefs, professional protectionism and individual’s perception of security as part of a sense of association.

Best and Williams (2019) related the intersection of IC and professional identity within interprofessional teams referring to challenges of diversity of teams. By an evaluation of boundary-spanning roles, Gilbert (2016) proposed the capacity to deliver a true IC service was limited as they are uniprofessionally founded, hence not fully boundary spanning. Further studies report boundary spanning can result in “entrenched protectionism” (Christmas and Millward, 2011), Nasir *et al.* (2013) termed this as professional “Turf Wars”. Similarly, Fraser (2019) explored staff perceptions of collaborative working within a

community IC team suggesting differences between professions such as professional values as one of the main challenges to IC.

As IC will continuously encompass changes for the workforce (RAND Europe *et al.*, 2012 and Imison *et al.*, 2017), in terms of culture it denotes a far more challenging agenda as Hudson (2015) argues, the defining role of culture in reform agendas is often understated and refers to Drucker's proverb which captures this aptly "Culture eats strategy for breakfast" (Drucker, n.d.). This is imperative as disconnection is an absolute risk to any organisation's success with the organisational transformation being the alignment of strategy and culture (Rick, 2014). Hudson (2015) concluded a disproportionate effort in IC discourses on finance and structural reforms with less emphasis on the underlying issues of culture, more specifically collaborative organisational cultures.

Furthermore, IC interim reports reveal barriers to integration are the "harder" featured issues associated to structures, systems and structural organisational differences with competing visions and operational policies (Erens *et al.*, 2015; Wistow *et al.*, 2015). This is important as research indicates community professionals' perceptions of social workers differ compared to health colleagues demonstrating a sense of frustration and from a position of disempowerment and exclusion, with cultural bias a negative experience for professionals and a lack of shared socialisation including development of a shared culture (Phillipowsky, 2018).

Baxter *et al.*'s (2018) systematic review of IC indicated organisational change in relation to IC models was rarely mentioned. However, Coupe (2013) argues for organisational viability as a crucial success factor for the paradigm of IC. Concurrently, for sustainability of change at organisational level, collective leadership and cooperation are key (Aungst *et al.*, 2012; Metcalf and Benn, 2013; Wiggins, 2016). Likewise, further studies signify co-location of the workforce during the process of integration as an emerging theme interlinked with improved communication through collaborative working relationships (Mackie and Darvill, 2016; Lees *et al.*, 2017).

A systematic review emphasised that no comprehensive, peer-evaluated longitudinal studies in the United Kingdom have been directed on integrated health and social care, resulting in ambiguity regarding long-term effects (Mackie and Darvill, 2016). Despite the importance of IC and the workforce, there remains a dearth of empirical research particularly related to workforce perceptions and experiences within a fully integrated care system in the community setting, indicating the need to understand what matters to the workforce to enable ICs to respond, adapt and deliver optimum sustainable IC to the health and care economy.

The intent of the research was to find answers to the following questions:

- (1) From a workforce perspective, what does the concept of integrated health and care in the community mean to staff?
- (2) What is the workforce's understanding of the principle characteristics of the new way of working?
- (3) What are the perceptions of the workforce regarding enablers, barriers, benefits and challenges to integrated health and care in the community?
- (4) How engaged are the workforce with the process of amalgamation of integrated health and care? (This relates to the joining together of both health and social care in one organisation).

For the purpose of this study, the researcher refers to the participating organisation as: IC with one organisational system, structures and processes following a full merger of community health and care service provision to the local population.

Research design

The operating paradigm for this study was “interpretive” also recognised as naturalistic or constructivist involving researchers integrating human interest into a study (Davies and Fisher, 2018), with interactive, flexible and inductive methods capable of gaining access to people’s subjective experiences and perceptions (Parahoo, 2014; Creswell, 2014).

Research strategy

To achieve the aim of this study, a qualitative research approach adopted the application of Colaizzi’s (1978) descriptive phenomenology seven-step method to analyse data collated from in-depth semi-structured interviews. This study explored and elicited the experiences of participants through their direct exposure to the context of IC in the community from their own words via in-depth semi-structured interviews, staying close to the phenomenon of the study to comprehend the fundamental structure of experiences (Edward and Welch, 2011).

Sample methods

The sample option was the subset of the health and care workforce on the basis they were best placed with exposure to IC within their professional roles in the community to ensure what is collated is a thick description of the phenomena rooted in first-hand experiences (Rubin and Rubin, 2012). The sampling frame criteria were identified as registered professionals consisting of social workers, allied health professionals or community nursing and have experience of integrated health and care in the community. Approximately 400 staff were drawn from these delimitations.

This was a small, localised study and not determined by the research sample size, rather by rich descriptions of the participants with three participants or more being credible for variation to gain essence (Giorgi, 1975, 2009). Lester (1999) concurs with this, claiming in phenomenological research a sample of single figures is valid. The researcher aimed to include a maximum of six participants, acknowledging the study findings cannot be extrapolated to all health and care professionals as it was not the researcher’s intent to generalise the findings, a deeper understanding was the objective of this phenomenological study (Van Manen, 1990; Polit and Beck, 2014).

Ethical considerations

Ethical approval for this study was granted on the 9th August 2019 from the University of Chester Research Ethics Sub-Committee of the Faculty of Health and Social Care. Both participants and their organisation involved in this study were notified they would not be identified in any subsequent report or publication.

Data collection

Englander (2012) proposed to explicate the phenomenon in question by engaging participants in open-ended questions. A pre-prepared interview schedule was formulated with open-ended questions outlining the main areas, flexible in relation to the phrasing of questions, use of prompts to guide uncertainty or incomprehension revealing knowledge and expounding points of interest (Denscombe, 2014; King *et al.*, 2019), increasing the validity of the study by the collation of rich data for analysis (Giorgi, 2009).

All five face-to-face semi-structured in-depth interviews were conducted at the participants’ choice of venue. Data collection took place between October and November 2019 consisting of two community nurses, two social workers and one allied health professional.

The researcher independently transcribed the five audio recordings from the semi-structured interviews verbatim for analysis. Data saturation determines the sample size as no new additional data or emergent themes would arise from interviewing further participants (Given, 2016). In this study data was saturated at five participants as no new themes or new information was generated as defined by similarities of participants' responses.

Data analysis and data reduction

Data analysis based on Husserl's descriptive phenomenology was adopted for this study with Colaizzi's (1978) seven-step process – descriptive phenomenological method, incorporating searching for common patterns produced from specific experiences and describing the meaning of an experience via emergent themes (Reiners, 2012). Reflexively "bracketing" was adopted during all stages of the data analysis to capture any evoked thoughts, feelings and ideas to support exploration of the phenomenon as experienced by the participants only (Shosha, 2012; Morrow *et al.*, 2015).

The researcher adopted "bracketing" as themes resonated with personal experience. In particular, one participant was in a role similar to one the researcher held previously closely linked to IC transformation and felt similar feelings about enablers and barriers. Validation of the fundamental structure identified four out of five returned responses were positive reflecting the participants' accounts only with none of the researcher's experience of IC influencing the fundamental structure. Adopting the "member checking" strategy is argued to add rigor to a study (Marshall and Rossman, 2006; Speziale and Carpenter, 2007; Creswell, 2014).

Findings

Theme one: insight of IC and collaboration

Theme one describes the participants' individual understanding and experience of what the concept IC in the community means to them interwoven with collaborative working. A variety of responses were expressed highlighting differing accounts of IC with multidimensional meanings and complexity fundamental to collaboration. When the terminology "Integration" was discussed, it was used interchangeably with reference to IC.

Excerpts from participants

One participant stated:

... sometimes there is a mis-perception about what integration means, so for me integration does not just mean being based in the same location, it's around having shared goals and those goals being very centred around the person which I feel should then improve outcomes

Another participant alluded to strength-based, focussing on people's strengths whilst visualising two strands to integration from a neo-liberal side, whereby there is less involvement with service users as the fittest look after themselves and the other strand which is strength-based with joined up thinking to support people in the community describing IC as:

... I can see two strands to it, I see the neo-liberal argument which is about... what a social worker is not so comfortable with... because it's about less involvement with the idea of like the fittest of the fit to look after themselves. However, the other side is kind of strength-based in that we should become resourceful which is good with health and have joined up thinking approaches to support people in the community

Another participant viewed IC from a coordination of care, working together, patient-centred and improved outcomes, describing IC as:

the concept of integrated care, I think is around that coordination of care from a health and a social perspective. Erm..it's about bringing together professionals to provide more patient-centred care, which I feel would improve outcomes

One participant with reference to integration acknowledged:

it's a better way to go but I think it takes time to fully integrate and understand the meaning of integration

Theme two: awareness of culture and professionalism

The second theme describes the participants' individual perceptions and experience of IC in the context of their awareness of professionalism in terms of professional identity closely associated to culture as a fundamental aspect of their IC journey.

This revealed optimism of trying to fit one into everything on their learning journey together and that a perceived barrier could be viewed as an opportunity for two differing organisations as:

culturally, I feel that again could be a barrier but again also you could see it as an opportunity, because actually two organisations are potentially have their own cultures. So when two big organisations come together you've got different cultures and different way of thinking, different visions, different values

One participant alluded to respect for other professionals' knowledge, skills and positive working atmosphere with a shared vision, stating:

There is respect for one another in terms of their knowledge base, their skills and just that working atmosphere that is positive, focused and people have the same vision

A participant described their initial concerns about losing social worker values, explaining:

I did not quite understand it at first, it was very much a kind of erm. . . the worry about losing the social working values with such a clinical team

The participant added a description about the feeling of losing professional identity, saying:

. . . it was mainly the losing identity and being able to work alongside people that had total different priorities

It was indicated they no longer work in silos and this improves the holistic approach to patient care, expressing:

Having more of a holistic assessment, so you know you are not just saying about your own area of practice in isolation, you are really thinking about how other things impact

Furthermore, the need for equal value of professionals within the culture of the workforce was recognised and the notion of the need for societal change referring to the equal value of professionals was expressed:

The [organisation] have done it quite well because they have changed it from our kind of community led way but there needs to be more of a cultural society change so that everyone. . . it's not just about the clinical side of things, social work comes after. It needs to be everything together, our team have recognised that, all professionals can work really well together and feed into a much better assessment

I think we need to be more of a societal change to recognise that all these professionals are equally as valid as each other

Theme three: impact of workforce engagement

The third theme describes all the participants' individual perceptions and experience of IC in the context of the impact of the organisations' engagement with the workforce in terms of the transition and amalgamation of the two organisations associated to co-location as a fundamental aspect of their IC journey.

One participant alluded to their role not having much involvement in the process of IC transition but the organisation staff engagement was felt to have been good, voicing:

I guess because of the role that I was in when we integrated I did not have a great deal of involvement in the process, however, from a Trust wide kind of staff engagement perspective I felt that it was good

The participant later expressed:

... we had leadership events around the time erm.. and it was very much focussed on, you know, welcoming adult social care, then having that opportunity to talk about their background, where they have come from and what their roles were and what their hopes were

One participant described their feeling of limited staff engagement in restructuring and redesigning of workspace, expressing:

There was a lot of restructuring and redesigning of the facilities which really affected the way the existing healthcare providers and the nurses felt and erm ... I still can remember the occasions when you are just coming in and saying you need to move today

A participant alluded to most bases (place of work) now having health and care in the same locality, stating:

the fact that in the majority of our bases now we have social workers, nurses and therapists all sitting together in the same locality, that just breeds familiarisation and it breeds openness and it enables those conversations to happen

Theme four: impact of organisational structure

Theme four describes a variety of responses from participants' individual understanding and experience of the impact of organisational structure in terms of processes and systems within an integrated health and care organisation.

Recognising and embracing differing regulators, frameworks and professional standards was noted:

we've got different regulators for health and social care, and actually trying to provide that evidence, you know, we have a certain framework to gather that evidence. We have our CQC framework whereas health and social care, sorry social care, have a different framework they have their professional standards. But I feel as an organisation we are recognising those differences and embracing them

Additionally, it was described that prior to integration there was a potential for system error as governance frameworks were different, voicing:

... previously we might have a number of systems operating in parallel, erm ... different governance frameworks, that to me gives room for error

In terms of the IT system infrastructure to support IC across health and care, a barrier to having differing IT platforms was indicated, stating:

Unfortunately different specialties work on different IT platforms and a lot of the barriers are around getting those IT things to work together

The positive progression of IT infrastructure for health with recognition of the interoperability of IT systems still not being fully compatible for both health and social care was reported:

recently we have had some interventions within our health infrastructure in that we can have read only access to other parts of the record and that sort of thing which is absolutely brilliant, but they still do not fully talk to each other and we still cannot see our social work colleagues information on their system, yet

Competency of health and care colleagues in terms of their IT skills being a barrier was alluded to:

... there are still barriers because there are still clinicians and social workers and all the rest of it out there that are not as perhaps IT literate as others. And I think sometimes as an organisation we could do more to help

Discussion

This study explored and captured the essence and reality of workforce perceptions, experiences and understanding of IC in a health and care NHS organisation in the community with the formulation of four emergent themes.

Theme one: insight of IC and collaboration

The first theme describes the individual participant's insights, understanding and experience of IC within the community interconnected with collaborative working. This study indicated the primary perceptions and experiences of IC were the opportunity for collaboration in the context of working together with shared goals and vision for better outcomes for people in the community. This resonates with previous studies that highlight the facets of IC success for the workforce are shared vision, values, goals, understanding of goals and the principle of joined up working across health and care professionals for improved outcomes (RAND Europe *et al.*, 2012; Zakaria, 2015; Erens *et al.*, 2017; Klinga *et al.*, 2016).

A positive feeling for building cohesion in terms of improved systems reducing duplication of roles was found. This is consistent with prior studies that reveal the concepts of development of working relationships, learning, networking and understanding differing roles subsequently improved responses to patients' needs across the health and care economy (Lees *et al.*, 2017; Fraser, 2019).

Recognition of dovetailing professional skills, knowledge and experience whilst reducing the impact of the duplication of roles featured in this study. This finding is congruent with previous research as Hunt (2014) highlighted an IC pioneer site "Test and Learn hub" found prior to integration, health and care professional barriers existed due to silo working compared to IC which wrapped together health and care professional skills, knowledge and expertise with the patient being the focal point.

This study highlighted professional aspirations of delivering holistic, person-centred and strength-based care within an integrated care system. The concepts of person-centred care or holistic care within IC feature in the literature (WHO, 2015; HCHSCC, 2018; Charles, 2019). However, current literature did not reveal the terminology of strength-based care in relation to IC systems, thus revealing this study perhaps found a new understanding of differing use of language from social care who described both person-centred and strength-based care. This finding indicates a possible explanation of a fundamental difference in professionals' approaches to a person's needs. This is important in terms of ensuring the workforce has a common understanding and expectations for IC success (Coupe, 2013).

A commonality revealed across participants was the direction of travel for IC in the community is fundamentally the right thing to do with a collaborative approach to integration. This is congruent with the NHS Long Term Plan for ICS's vision of collaboration across organisational boundaries and advancing care closer to or at home with fully IC within the community (NHS England, 2019a; Murray, 2019).

This study indicated optimism for IC and the perception that IC necessitates time to embed. The notion of "time to embed IC" is consistent with previous research from a seven-country cross-case analysis of the principles of IC asserting integration takes time to build (Wodchis *et al.*, 2015). Similarly, Edwards (2018) stressed new models of integration take time including the learning and development of differing organisational inter-relationships. This is an important finding for NHS organisations to ensure time is factored into any IC strategies and that the workforce is collectively embracing their IC journey.

Theme two: awareness of culture and professionalism

This study revealed an interesting insight highlighting the necessity to work collaboratively as partners of care with equal value across all communities within the health and care economy and signifying equal value of professionals from wider society, calling for "*societal change to recognise that all professionals are equally as valid as each other.*" This appears a complex phenomenon incorporating people's perceptions of health and care professionals with the potential to add a differing and further dimension to IC.

Participants found the transition into IC challenging, fear of losing their professional identity which resonates with literature asserting perceived fear of dilution of professional identity within integration (Pate *et al.*, 2010; Cameron *et al.*, 2014). However, participants within this study embraced the opportunity to collaborate inter-professionally, avoiding silo working whilst recognising the importance to maintain their professional identity and valuing all professionals. This finding is contrary to previous research stating integration and boundary spanning have resulted in "entrenched protectionism" (Christmas and Millward, 2011). Nasir *et al.*'s (2013) longitudinal study exploring health care and non-health knowledge across all health and care systems described boundary spanning as professional "Turf wars". Conversely, an IC pioneer site study identified IC offers the ability to retain your specialism, sharing expertise and working together for the benefit of patients (Hunt, 2014). This is consistent with the findings of this study as it was clear from all participants the importance of working together, maintaining their professional identity with an inter-professional approach with equal value of all professionals from within the culture of the workforce.

The findings of this study indicated an awareness and understanding to develop a culture of trust and professionalism with differing cultures, values and visions. Participants described IC as requiring the development of working relationships, respect, trust, understanding of roles and appreciation of the benefits of differing knowledge and skills for patient outcomes. There was positivity from all participants regarding these imperative facets for the success of IC resonating with (RAND Europe *et al.*, 2012), Round *et al.* (2018) suggest system change, in time, results in a culture of collaboration with shared culture and ownership the key to success. In contrast, other previous studies assert culture to be a perceived barrier to IC Busetto *et al.* (2018) and cultural bias resulted in a lack of a shared socialisation and culture (Phillipowsky, 2018).

Theme three: impact of workforce engagement

Impact of workforce engagement suggested participants regarded staff engagement in the process of decision-making to be mixed with varying levels of engagement from no involvement to active roles. This was particularly noted with information sharing from the

organisation perceived as good with opportunities to collectively learn and share experiences and hopes. The commonality of limited engagement in relation to restructuring, redesigning and allocation of workspace was important to the workforce with a potential to impact on people's well-being and the success of integration.

This study resonates with the NHS Staff Survey (NHSSS) [NHS England, \(2019b\)](#) intent to make improvements in staff experience, motivation and well-being with the NHSSS 2018 results indicating good staff engagement is due to intrinsic motivation and commitment of staff ([West, 2019](#)). A previous study recognised the value of provider engagement process indicating professionals were less likely to be cognitively, emotionally and physically engaged without support or resources at manager and organisational level ([Ignatowicz et al., 2014](#)). These qualities are important at local level and across the health and care system as staff engagement is a fundamental enabler for IC and engaging staff early in the process of service redesign is an opportunity to value the workforce and yield quality patient outcomes ([McMenamin and Mannion, 2017](#); [Curry, 2019](#)).

Theme four: impact of organisational structure

A commonality across all participants was perceptions and frustrations of IT not being fully integrated due to differing IT platforms not affording interoperability with one system record to one patient. This was further impeded with perceptions of differing IT literacy skills with an awareness that IT operability affords greater holistic assessments for patients with the ability to identify and mitigate risks. This finding is fundamentally critical to the organisations' technology systems, processes and interactions to support safe, effective practice in line with the NHS Long Term Plan vision to enable service transformation, helping clinicians maximise their skills to ensure data is both accessible and interoperable through mandate and rigorous technology standards ([NHS England, 2019a](#)).

This study found an awareness of the governance structure in terms of regulators from social care with professional standards and health being regulated by the Care Quality Commission. Prior to integration there were differing systems operating in terms of governance systems and were perceived as a potential for system error, this marginalisation of error is now felt to be reduced with organisational recognition of the differences. Participants voiced their frustration of the need for standardising training needs with an awareness of differing timeframes and expectations between health and care professionals' responses to patients' needs raising a feeling of ambiguity of roles. These facets were expressed as important aspects by the participants and are similar to IC interim reports that reveal barriers to integration are the "harder" featured issues associated to structures, systems and structural organisational differences with competing visions and operational policies ([Erens et al., 2015](#); [Wistow et al., 2015](#)).

An interesting finding of this study found leadership not to be a prominent feature amongst participants. Whilst leadership may not have been explicitly voiced, a plausible explanation may be because leadership is intrinsically a given phenomenon. Equally, leadership was not a formulated question or prompt during the interviews. Additionally, there was a feeling of positivity from all participants in terms of recognising and embracing IC new way of working which highlights the organisations' IC journey success and ability to embrace the challenges.

Conclusion

The findings of this study suggest collaborative partnership working, staff engagement, culture, professionalism and organisational structures are the fundamental features of IC. This highlights the importance of valuing and understanding the uniqueness of the

workforce perspectives through lived experience in practice. Seek to listen, understand and learn what matters to people with the “voice of the workforce” a critical factor to support the IC agenda. A key barrier highlighted multiple IT platforms prevent full integration as it currently does not afford interoperability with one system record to one patient, further hindered by differing levels of IT literacy.

The study offers an insight and understanding of IC experienced by professional aspirations focussing on “strength-based care” and “person-centred care”, improving outcomes for people in the community. Interestingly, the differing use of terminology with social worker colleagues using both “strength-based care” and “person-centred care”, whereas health professionals used only “person-centred care” indicating a possible fundamental difference in professionals’ approaches to a person’s needs and the necessity for a common understanding.

At national level the success of the NHS Long Term Plan in terms of ICSs [NHS England \(2019a\)](#) and the People Plan [NHS England \(2020\)](#) is dependable on the key contribution of the health and care workforce. It is vital that health and care systems collaborate to lead their local workforce [NHS Improvement \(2019\)](#), raising the importance for IC strategies or policy to incorporate and embed the “voice of the workforce perceptions and experiences” as key enablers for IC to be a fully collaborative approach with improved outcomes.

Study’s recommendations

- (1) To consider exploring a commonality of a shared understanding of language for health and care professionals and standardisation of professional training in order to resolve ambiguity of roles and support the delivery of IC.
- (2) To explore IT systems with interoperability across the health and care system.
- (3) To consider future research including longitudinal studies accessing a wider pool of the workforce perspectives of IC across the interface of primary care networks, commissioners, acute and independent providers to support the direction of travel for sustainable IC.
- (4) Influencing societal change would warrant further insights, understanding and future research locally, nationally and on a global platform to raise the equal profile of all professionals’ unique contribution to IC to reach world health recognition and potential future health care sustainability.

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